Supreme Court, U.S.
FILED
OCT 4 1995
CLERK

No. 94-1818

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

EQUICOR, INC.,

Petitioner,

v.

LORDMANN ENTERPRISES, INC.,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

SUPPLEMENTAL BRIEF OF PETITIONER

H. SANDERS CARTER, JR.
CARTER & ANSLEY
Suite 1000
191 Peachtree Tower
191 Peachtree Street
Atlanta, Georgia 30303
(404) 658-9220

* THEODORE B. OLSON
MARK SNYDERMAN
GIBSON, DUNN & CRUTCHER
1050 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 955-8500

* *Counsel of Record*

Attorneys for Petitioner

PRESS OF BYRON S. ADAMS, WASHINGTON, D.C. 1-800-347-8208

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	ii
SUPPLEMENTAL BRIEF OF PETITIONER.....	1
CONCLUSION	10

TABLE OF AUTHORITIES

Page(s)

Cases:

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981)..... 8

Baker Hosp. v. Aetna Life Ins. Casualty Co., 1991 WL 179113 (4th Cir. 1991)..... 3

Baker Hosp. v. Isaac, 391 S.E.2d 549 (S.C. 1990).. 3

Barnes Hosp. v. Sanus Passport/Preferred Servs., Inc., 809 F. Supp. 725 (E.D. Mo. 1992)..... 4

Beth Israel Medical Center v. Sciuto, No. 92 Civ. 8729 (RPP), 1993 WL 258636 (S.D.N.Y. July 8, 1993) 4

Brown Schools, Inc. v. Florida Power Corp., 806 F. Supp. 146, 150-51 (W.D. Tex. 1992)..... 5

Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991), *cert. dismissed*, 113 S. Ct. 2 (1992)..... 2,3

Forest Springs Hosp. v. Illinois New Car & Truck Dealers Ass'n Employees Ins. Trust, 812 F. Supp. 729 (S.D. Tex. 1993) 4

Hermann Hosp. v. MEBA Med. & Benefits Plan, 845 F.2d 1286 (5th Cir. 1988), *adhered to on appeal after remand*, 959 F.2d 569 (5th Cir. 1992)..... 3,4

Memorial Hospital Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990)..... 4,6,9

Page(s)

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985)..... 7

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671 (1995) 1,2,6,7

Northwestern Inst. of Psychiatry, Inc. v. Travelers Ins. Co., No. 92-1520, 1992 WL 236257 (E.D. Pa. Sept. 3 1992), *modified on other grounds*, 1992 WL 331521 (E.D. Pa. Nov. 3, 1992) 4

Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs., 788 F. Supp. 1002 (N.D. Ill. 1992) 5

Psychiatric Inst. of Washington, D.C. v. Connecticut Gen. Life Ins. Co., 780 F. Supp. 24 (D.D.C. 1992)..... 4

Rehabilitation Inst. of Chicago v. Group Administrators, Ltd., 844 F. Supp. 1275 (N.D. Ill. 1994)..... 4

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) .. 8

Statute:

Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001 *et seq.* .....*passim*

SUPPLEMENTAL BRIEF OF PETITIONER

Petitioner Equicor, Inc. submits this supplemental brief in response to the brief for the United States as amicus curiae. The government argues that this Court should not grant the petition for writ of certiorari, but ignores the pressing need for certainty on an issue critical to the efficient delivery of health care. The government's erroneous position on the merits also is affected by its failure to appreciate fully the impact of the Eleventh Circuit's decision on employee benefit plan administration. The government's unduly expansive reading of *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S. Ct. 1671 (1995), exacerbates the misimpression its brief advances.

1. The question presented in this case is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001 *et seq.*, preempts a state law claim brought by a health care provider against an employee benefit plan administrator for alleged tortious conduct in the administration of the plan. Specifically, can a health care provider sue an employee benefit plan administrator under state law because the provider relied upon alleged characterizations by the administrator regarding coverage under the plan? The interactions that give rise to such claims are commonplace. Health care providers phone medical plan administrators tens of thousands of times each day inquiring about covered expenses under a patient's employee benefit plan. The question here is whether the plan administrator's legal obligations in responding to these myriad inquiries are to be governed by a uniform body of federal law, or to be determined according to the diverse requirements of the several states.

It would be difficult to understate the importance of this question for plan administrators, plan sponsors, and employee benefit plan beneficiaries. The accumulation of state law liability on top of a plan administrator's ERISA obligations necessarily will alter plan administration and increase costs, not only because of differences in substantive requirements but also because state law may provide for punitive damages or other recovery not available under ERISA. These administrative changes and additional costs will be felt by plan sponsors, who pay for plan administration, and by plan beneficiaries in the form of less efficient administration, higher deductibles and copayments, and fewer covered services.

The great prevalence of state law claims like that in this case demonstrates not only the importance of the issue, but the necessity for this Court to announce a single rule. In its brief, the government overlooks the urgent need for certainty on an issue that arises with such extraordinary frequency. Regardless of what the Court ultimately decides, benefit plan administrators must understand fully their obligations and potential liability when communicating with health care providers. This Court can provide such service to consumers of the law.

The split of authority that the Eleventh Circuit's decision implicates, and the uncertainty it has created, is considerably more extensive than the government acknowledges. In addition to the Sixth Circuit's decision in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1275-76 (6th Cir. 1991), *cert. dismissed*, 113 S. Ct. 2

(1992),[1] the Fourth and Fifth Circuits and the Supreme Court of South Carolina also have held, contrary to the Eleventh Circuit, that ERISA preempts state law claims by health care providers against plan administrators. *See Baker Hosp. v. Aetna Life Ins. Casualty Co.*, 1991 WL 179113 (4th Cir. 1991); *Hermann Hosp. v. MEBA Med. & Benefits Plan (Hermann I)*, 845 F.2d 1286, 1290 (5th Cir. 1988), *adhered to on appeal after remand*, 959 F.2d 569, 576-79 (*Hermann II*) (5th Cir. 1992); *Baker Hosp. v. Isaac*, 391 S.E.2d 549, 550-51 (S.C. 1990).

The government's attempt to diminish the effect of these decisions is wholly unconvincing. For example, the government notes that the plaintiffs in the Fourth Circuit and South Carolina cases conceded ERISA preemption. U.S. Brief at 15 n.6. This distinction ignores that in both cases the court explained that such concessions were mandated by the law. The Fourth Circuit held that plaintiff's common law claims were "[i]ncluded within [ERISA's] statutory preemption." *Baker Hosp. v. Aetna*, 1991 WL 179113 *1. The South Carolina Supreme Court followed its discussion of the ERISA preemption issue with a declaration that it "ha[d] determined that the instant common law claims are pre-empted." *Baker Hosp. v. Isaac*, 291 S.E.2d

---

[1]The government does its best to deconstruct *Cromwell*, U.S. Brief at 15-17, but the fact remains that the Sixth Circuit's decision is squarely in conflict with the Eleventh Circuit's decision here. The government believes that *Travelers* has superseded Judge Suhrheinrich's concurring opinion in *Cromwell*, but the government badly misreads *Travelers*. *See infra* n.2.

at 551. As to the Fifth Circuit, the government claims that *Memorial Hospital Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990), distinguished *Hermann I*. U.S. Brief at 15 n.5. The government fails to cite *Hermann II*, in which the Fifth Circuit disavowed *Memorial Hospital* and reaffirmed the *Hermann I* holding that ERISA preempts a provider's negligent misrepresentation claim. 959 F.2d at 578.

The government also ignores that the confusion on this issue extends beyond the federal courts of appeal and state supreme courts. Several district courts in circuits that have not spoken on the issue have held that ERISA preempts provider common law claims. *See Barnes Hosp. v. Sanus Passport/Preferred Servs., Inc.*, 809 F. Supp. 725, 726-28 (E.D. Mo. 1992); *Psychiatric Inst. of Washington, D.C. v. Connecticut Gen. Life Ins. Co.*, 780 F. Supp. 24, 31-32 (D.D.C. 1992); *Northwestern Inst. of Psychiatry, Inc. v. Travelers Ins. Co.*, No. 92-1520, 1992 WL 236257 (E.D. Pa. Sept. 3 1992), *modified on other grounds*, 1992 WL 331521 (E.D. Pa. Nov. 3, 1992). Other district courts are aligned with the Eleventh Circuit. *See Rehabilitation Inst. of Chicago v. Group Administrators, Ltd.*, 844 F. Supp. 1275 (N.D. Ill. 1994); *Beth Israel Medical Center v. Sciuto*, No. 92 Civ. 8729 (RPP), 1993 WL 258636 (S.D.N.Y. July 8, 1993). Still others have reached mixed results. *See, e.g., Forest Springs Hosp. v. Illinois New Car & Truck Dealers Ass'n Employees Ins. Trust*, 812 F. Supp. 729, 731-33 (S.D. Tex. 1993) (negligent misrepresentation claim not preempted, but equitable estoppel claim preempted). Finally, some courts look to the nature of the alleged representations, and find preemption where the representations would have the effect of modifying the

terms of the ERISA plan, while denying preemption where the representations merely interpret ambiguous plan provisions or promise benefits in the absence of any coverage at all. *See Brown Schools, Inc. v. Florida Power Corp.*, 806 F. Supp. 146, 150-51 (W.D. Tex. 1992); *Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs.*, 788 F. Supp. 1002 (N.D. Ill. 1992).

The existing disharmony among so many courts represents the worst possible situation, increasing confusion as to what laws apply, encouraging disputes and litigation and fostering inconsistent results. It is important that this chaos, which is bad for employers, providers and plan administrators alike, be resolved. Review in this case would allow the Court to eliminate all of this uncertainty.

2. Review also would allow this Court to reverse the Eleventh Circuit's erroneous ERISA preemption decision. The government defends that decision, but in so doing evinces the same misunderstanding of plan administration and the claims at issue that plagues the Eleventh Circuit's opinion. The government argues, for example, that the state law claim at issue here does not "relate to" an employee benefit plan because "[t]he cause of action for negligent misrepresentation under Georgia law does not refer to, and is not dependent on, the existence of an ERISA plan." U.S. Brief at 7. This is plainly incorrect. A claim of negligent misrepresentation presupposes that the defendant has misrepresented *something*. In this case, and others like it, the provider claims that the plan administrator misrepresented coverage under the plan. The cause of action refers to and is dependent on the plan.

Moreover, claims like that at issue in this case "relate to" employee benefit plans because they have a profound effect on plan administration. The government contends that these claims "ha[ve] no direct economic or administrative impact on the ERISA plan." U.S. Brief at 8. But the government is viewing each of these claims in a vacuum. Contrary to the government's position, provider suits do *not* represent "'one-time recovery [that] would not affect . . . on-going administration.'" *Id.* at 8 (quoting *Memorial Hospital*, 904 F.2d at 247). Plan administrators supply to providers information on plan coverage on a constant basis; the threat of state law claims arising from this vital aspect of plan administration is ever-present. If plan administration is to be wrenched from a uniform body of federal law and subjected to the vagaries of state tort litigation, with the possibility of uncontrollable punitive damages, administrators will adjust their provider interactions to take these costs into account. Administrators will be forced to take precautions that increase the cost of administration and make it more difficult for providers to assess quickly a patient's benefit plan coverage. These administrative changes will be felt by plan beneficiaries.[2]

---

[2]The government argues that these are merely cost effects, and as such represent nothing more that "the type of indirect and purely economic impact on plans that *Travelers* held insufficient to trigger preemption." U.S. Brief at 8 n.1. This argument proves decidedly too much, for it would protect from ERISA preemption all state substantive regulation of plans, a result the *Travelers* Court plainly did not contemplate.

In *Travelers*, this Court held that ERISA generally does not preempt state laws that have only an indirect economic effect on employee benefit plans. 115 S. Ct. at 1680. State common law

claims like those at issue here are not merely economic regulation; they compel plan administrators to make substantive changes in plan administration. Ultimately, of course, the cost of these changes can be calculated in dollar terms; the "cost" of these claims translates to more expensive administration and medical care. But if these claims represent "purely economic" regulation, as the government contends, because adaptation means spending more money, *all* substantive requirements imposed on plans are purely economic regulation because compliance in all cases can be reduced to additional cost. By the government's reasoning, all such laws are thereby protected from ERISA preemption.

That result is obviously incorrect, and plainly contrary to this Court's authority. For example, the state law at issue in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), mandated that all health insurance policies provide coverage for mental health benefits. *Id.* at 727. From the perspective of an employee benefit plan purchasing health insurance, compliance with the law meant spending more money for the additional insurance coverage and the cost of administering the additional benefits. Despite the ultimately economic effect of the legislation, this Court had little difficulty concluding that the Massachusetts law "related to" employee benefit plans. *Id.* at 739. Regardless of its monetary impact, the law imposed real substantive requirements on the plan. The Court reaffirmed the *Metropolitan Life* holding in *Travelers*--noting that the Massachusetts law imposed a "substantive" requirement on plan administrators--even as it was declaring that purely indirect economic regulation is not preempted. 115 S. Ct. at 1680-81.

Like the mandatory benefit law at issue in *Metropolitan Life*, and unlike the hospital surcharges at issue in *Travelers*, common law misrepresentation and estoppel claims are more than mere economic regulation. They are substantive regulation that governs administrative practice and "relates to" employee benefit plans.

As the government correctly notes, ERISA establishes "a uniform set of regulations governing . . . procedures for processing claims and paying benefits." U.S. Brief at 10. This "comprehensive scheme," *id.* at 12, works ultimately to the advantage of beneficiaries by simplifying the environment for plan administration. ERISA occupies the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98-99 (1983). The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the market and the discretion of plan administrators. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

State law claims of the sort at issue here threaten this scheme. ERISA preempts state misrepresentation and estoppel claims by plan beneficiaries, as the government concedes, leaving the resolution of disputes over benefits to the exclusive jurisdiction of ERISA and the terms of the plan. U.S. Brief at 12-14. The "regulatory void" for misrepresentation and estoppel claims represents a particular balance struck between the costs of this form of litigation and the possibility that some error, or claimed error, in supplying information might go unremedied. The purposes served by this exclusive regulatory scheme do not change when providers rather than beneficiaries sue. From the perspective of plan administration, provider inquiries and provider law suits impose the same costs as those involving beneficiaries. Because a provider law suit to recover "promised" plan benefits relates to an employee benefit plan every bit as much a similar suit by a beneficiary, ERISA strikes the same balance.

The government argues that provider suits can be distinguished from suits by beneficiaries because beneficiaries are held responsible under ERISA to know the terms of the plan, while providers are not. U.S. Brief at 14. Such a distinction undercuts entirely the ERISA scheme that holds beneficiaries to the terms of the plan, for provider suits allow beneficiaries an easy means for circumventing these requirements. According to the government (and the Eleventh Circuit), as long as the provider, rather than the beneficiary, calls the plan administrator to inquire about plan coverage, the terms of the plan no longer serve as a limitation on benefits available. This scenario provides yet another clear indication that provider suits "relate to" employee benefit plans.

In the end, the government cannot maintain the line it wishes to draw between the present claims and other preempted state regulation. The government claims that "misrepresentation claims raised by health care providers do not 'raise[] any issue concerning the matters that Congress intended to be regulated exclusively by ERISA,'" U.S. Brief at 9 (quoting *Memorial Hospital*, 904 F.2d at 247), while at the same time maintaining that preemption of provider claims "would directly undercut the interests of participants and beneficiaries" that constitute the purpose for which Congress enacted ERISA. *Id.* at 10. The government is (nearly) right the second time; provider suits very much affect plan administration and the interests of

plan participants and beneficiaries.[3] That is precisely why ERISA preempts such claims.

CONCLUSION

For the foregoing reasons, and those stated in the petition for writ of certiorari, this Court should grant the petition, set this case for plenary review, and reverse the judgment of the Eleventh Circuit.

Respectfully submitted,

H. SANDERS CARTER, JR.
CARTER & ANSLEY
Suite 1000
191 Peachtree Tower
191 Peachtree Street
Atlanta, Georgia 30303
(404) 658-9220

*THEODORE B. OLSON
MARK SNYDERMAN
GIBSON, DUNN & CRUTCHER
1050 Connecticut Ave., N.W.
Washington, D.C. 20036
(202) 955-8500

Attorneys for Petitioner

**Counsel of Record*

---

[3]The government also may be right that preemption of such suits ultimately works to the detriment of participants and beneficiaries. Perhaps the dramatic recent changes in health care administration have shifted the balance that ERISA strikes. Perhaps the opportunities for administrative misinformation have become so great that beneficiaries and providers should no longer have to bear the risk of these errors. The resulting inequity, if any, should be resolved by Congress, however, and not by filling the void with remedies under 50 different state laws.